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No. _____

In the
SUPREME COURT OF THE UNITED STATES
October Term, 1994

EQUICOR, INC.,
Petitioner,
v.
LORDMANN ENTERPRISES, INC.,
Respondent.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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May 2, 1995

QUESTION PRESENTED

Does ERISA preempt state law tort claims brought by a health care provider against an ERISA benefits administrator, when the conduct alleged to be tortious occurred in the performance of the administrator's duties as an ERISA plan fiduciary?

PARTIES TO THE PROCEEDING

In addition to the named parties, petitioner states pursuant to Sup. Ct. R. 29.1 that CIGNA Corporation is the parent company of petitioner.

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OPINION BELOW

The opinion of the United States Court of Appeals for the Eleventh Circuit (COX, Circuit Judge; MORGAN Senior Circuit Judge; and COLLIER, District Judge for the Northern District of Florida, sitting by designation) is officially reported at 32 F.3d 1529 (11th Cir. 1994) and is set forth in the appendix beginning at page A-1.

The opinion of the United States District Court for the Northern District of Georgia (Forrester, J.), has not been reported and is set forth in the appendix beginning at page B-1.

STATEMENT OF JURISDICTION

The decision and judgment of the United States Court of Appeals for the Eleventh Circuit were entered on September 26, 1994. (App. A-1.) Petitioner filed a timely suggestion for rehearing en banc on October 17, 1994. Pursuant to 11th Cir. R. 35-6, the suggestion for rehearing en banc also is considered a petition for rehearing. The petition for rehearing and suggestion for rehearing en banc were denied on February 1, 1995. (App. C-1.) This petition is filed timely and within 90 days of the denial by the Eleventh Circuit of the petition for rehearing. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

STATUTE INVOLVED

Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a), is involved in this petition and is reproduced in full in the appendix at page D-1.

STATEMENT OF THE CASE

The issue presented by this petition involves the extent of ERISA preemption of state law under circumstances that are "reenacted each day across the country." Memorial Hospital Systems v. Northbrook Life Insurance Co., 904 F.2d 236, 246 (5th Cir. 1990). Specifically, a medical care provider claims that it rendered medical care based upon allegedly false information provided by the benefits administrator regarding the patient's eligibility for benefits under an employee welfare benefit plan.

Respondent, Lordmann Enterprises, Inc., provided private duty nursing services to Victoria Mitchell, the infant daughter of Paula Rebecca Mitchell. Victoria was born with severe birth defects which necessitated home nursing care after her discharge from the hospital. Ms. Mitchell hired a nurse employed by respondent to provide that care.

Ms. Mitchell and Victoria were eligible participants in an employee welfare benefit plan sponsored by Hi-Fi Buys, Inc., Ms. Mitchell's employer. Under the terms of the plan, Ms. Mitchell and Victoria were entitled to health care benefits provided by a group insurance policy issued by First Equicor Life Insurance Company. Petitioner, Equicor, Inc., administered benefits and claims under the plan.

The plan is an employee welfare benefit plan as defined by ERISA, 29 U.S.C. § 1002(l) and (3). According to the terms of the plan, charges for private duty nursing, such as that provided by respondent, were covered for up to thirty (30) days in a calendar year.

Respondent contends that, after it began providing nursing services to Victoria, its chief executive officer, Susan Marot, had several telephone conversations with Geri Castagno, an employee of petitioner. According to

Ms. Marot, Ms. Castagno represented that respondent's home nursing services would be "paid in full" by the plan.

Ms. Castagno admits that she spoke to Ms. Marot but denies that she said anything except that petitioner would pay for the nursing care according to the terms of the plan.

Respondent continued its care for Victoria for approximately six months and thereafter sought payment from petitioner. Petitioner paid respondent all benefits for which it was obligated under the written terms of the plan.

Respondent sued petitioner on July 20, 1992, in the Superior Court of Fulton County, Georgia, seeking to recover $59,432.40, the unpaid balance of its bill for services provided to Victoria Mitchell. Petitioner timely removed the case to the United States District Court for the Northern District of Georgia on August, 20, 1992, on the alternative bases of federal question jurisdiction, 28 U.S.C. § 1331, and diversity jurisdiction, 28 U.S.C. § 1332.

Respondent's complaint, as amended, contained four counts: Count I, brought under Georgia law, asserted a claim for fraudulent misrepresentation; Count II, also brought under Georgia law, asserted a claim for negligent misrepresentation; Count III asserted a claim based on ERISA for benefits under the employee welfare benefit plan; and Count IV asserted a claim based on the federal common law of equitable estoppel. Counts III and IV were asserted by respondent as assignee of Ms. Mitchell's rights under the plan.

On March 1, 1993, petitioner filed a motion for summary judgment as to all four counts, which was granted by the district court on October 2, 1993. (App. B-l.) Respondent timely appealed, and a panel of the Eleventh Circuit Court of Appeals affirmed the grant of summary judgment to petitioner with respect to Counts I, III, and IV. (App. A-1.) However, the Eleventh Circuit reversed the

district court's grant of summary judgment with respect to Count II, concluding that respondent's claim under Georgia law for negligent misrepresentation was not preempted by ERISA.

On February 1, 1995, the Eleventh Circuit denied petitioner's timely suggestion for rehearing en banc, which, under the rules of the Eleventh Circuit, also constituted a petition for rehearing. (App. C-1.) Petitioner now seeks a writ of certiorari to the United States Court of Appeals for the Eleventh Circuit.

REASONS FOR GRANTING THE WRIT

This Court should grant the writ of certiorari for two reasons: First, the opinion of the Eleventh Circuit is in conflict with a decision from the Sixth Circuit Court of Appeals, Cromwell v. Equicor-Equitable HCA Corp., 944 F.2d 1272 (6th Cir. 1991), cert. dismissed, __ U.S. ___, 113 S. Ct. 2, 120 L.Ed.2d 931 (1992); and second, the extent of ERISA preemption of state law involves an important question of federal law that has not yet been, but should be, settled by this Court.

Section 514(a) of ERISA provides, in pertinent part, that ERISA preempts "any and all State laws insofar as they now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). In Shaw v. Delta Airlines, Inc., 463 U.S. 85, 96-97 (1983), the Court interpreted ERISA's preemption provision liberally: "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection

with or reference to such a plan." However, the Court also said that some state laws may affect an ERISA plan "in too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Id. at 100 n.21. The Court's statements in Shaw do not provide an analytical framework to determine whether, and under what circumstances, a particular state law either "relates to" an ERISA plan and is preempted, or is "too tenuous, remote, or peripheral" to warrant preemption. As a result, the circuit courts of appeal have reached different results on the precise question raised in this case.

Unfortunately, the circuit courts of appeal employee the conclusory phrases -- "relate to" and "too tenuous, remote, or peripheral" -- instead of a structured analysis of the extent of ERISA preemption. More important, the circuit courts of appeal focus on whether the facts of these cases warrant the existence of a cause of action, rather than

whether the cause of action, if it exists, should be governed exclusively by federal law.

In Memorial Hospital Systems, supra, Hospice of Metro Denver, Inc. v. Group Health Insurance, 944 F.2d 752 (10th Cir. 1991), and The Meadows v. Employers Health Insurance, No. 93-16315 (9th Cir. Feb. 17, 1995), reprinted in 18 E.B.C. 2926, the courts held that state law causes of action asserted by medical care providers did not "relate to" the ERISA plans and were not preempted. On the other hand, in Cromwell, supra, the court concluded that a medical care provider's state law claim of promissory estoppel was preempted. The decision of the Fifth Circuit in Memorial Hospital, followed by the Eleventh Circuit in this case, by the Tenth Circuit in Hospice of Metro Denver, and by the Ninth Circuit in The Meadows, rests upon the relationship between the party plaintiff and the ERISA plan.

Preemption analysis premised on the identity of the party plaintiff is illogical and inconsistent with the ERISA goal of establishing a uniform body of law to govern the conduct of ERISA fiduciaries. In Shaw, supra, the Court quoted approvingly from several passages of ERISA's legislative history which explain the purpose and importance of ERISA's preemption provisions:

> Finally, I wish to make note of what is to many the crowning achievement of this legislation, the reservation to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation.

Representative Dent, 120 Cong. Rec. 29197 (1974), quoted in Shaw, 463 U.S. at 99.

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

Senator Williams, id. at 29933, quoted in Shaw, supra at 99.

In Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9-10 (1987), the Court elaborated on the intent of Congress represented by the quoted passages:

> These statements reflect recognition of the administrative realities of employee benefit plans. An employer that makes a commitment systematically to pay certain benefits undertakes a host of obligations, such as determining the eligibility of claimants, calculating benefit levels, making disbursements, monitoring the availability of funds for benefit payments, and keeping appropriate records in order to comply with applicable reporting requirements. The most efficient way to meet these responsibilities is to establish a uniform administrative scheme, which provides a set of standard procedures to

guide processing of claims and disbursement of benefits.

We have not hesitated to enforce ERISA's pre-emption provision where state law created the prospect that an employer's administrative scheme would be subject to conflicting requirements.

The Court concluded:

It is thus clear that ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers

> with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations.

Id. at 11.

Since the purpose of ERISA preemption is to establish a uniform body of law to regulate the duties and conduct of ERISA entities, preemption analysis should focus on the effect the state law would have on the conduct of the ERISA entity as an ERISA entity. If a state law tort cause of action arises because of conduct in which a plan fiduciary engages in fulfilling its ERISA obligations, the state law should be preempted without regard to the identity of the party plaintiff. Otherwise, the plan fiduciary would be subject to varying laws in structuring its conduct. As this Court said

in Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990):

> Allowing state based actions like the one at issue here would subject plans and plan sponsors to burdens not unlike those that Congress sought to foreclose through § 514(a). Particularly disruptive is the potential for conflict in substantive law. It is foreseeable that state courts, exercising their common law powers, might develop different substantive standards applicable to the same employer conduct, requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.
>
> Such an outcome is fundamentally at odds with the goal of uniformity that Congress sought to implement.

Unfortunately, the Eleventh Circuit decision in this case, adopting the analysis of the Fifth Circuit in Memorial Hospital, supra, did not analyze Congressional intent with respect to federal preemption. Rather, the decision was premised on two reasons, both of which are concerned with whether a cause of action exists, not whether any such cause of action is governed by federal law. The court's first reason for concluding that there is no federal preemption is based on the following logic:

(1) Congress enacted ERISA to "protect the interests of employees and beneficiaries covered by benefit plans," citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113 (1989);

(2) Health care providers must be able to rely on administrators' representations concerning eligibility and coverage;

(3) If health care providers cannot rely on administrators' representations of coverage, medical treatment would be more difficult to obtain;

(4) Thus, preemption of a third-party health care provider's state law claim of misrepresentation would defeat the Congressional purpose of protecting the interests of participants.

The court's conclusion is valid only if it is assumed that federal preemption eliminates the health care provider's ability to rely on communications from plan fiduciaries. And federal preemption would obviate the health care provider's reliance on such communications only if the health care provider had no alternative protection under federal law.

Thus, the real basis for the court's decision is the implicit assumption that health care providers would not have a remedy in the present circumstances if ERISA preempted state law.

The flaw in the court's reasoning is apparent. It simply is not relevant to an analysis of the scope of federal preemption whether, and to what extent, a plaintiff may be left without a remedy. Caterpillar, Inc. v. Williams, 482 U.S. 386, 391 n.4 (1987); see also Avco Corp. v. Machinists, 390 U.S. 557, 561 (1968).

The Eleventh Circuit's second reason for concluding that there was no federal preemption of state law similarly is founded upon a concern that the health care provider would be left without a remedy. The court reasoned:

(1) ERISA does not preempt "run-of-the-mill" claims by non-ERISA entities against ERISA plans, citing Mackey v. Lanier Collections Agency and Service, Inc., 486 U.S. 825, 832-33 (1988);

(2) Health care providers are not parties to the ERISA "bargain," since ERISA does not provide a cause of action for aggrieved health care providers; and

(3) Thus, ERISA a fortiori does not preempt claims by health care providers against a plan fiduciary.

By focusing on the remedy available, the court completely disregarded the effect of applying state substantive law on the administration of an employee benefit plan. Ignoring the effects on plan administration contravenes the principles set forth in Fort Halifax Packing Co., supra, in which the Court held that federal preemption under ERISA is intended to ensure that the administration of a benefit plan will be governed by a single set of regulations.

Additionally, the Eleventh Circuit's concern that health care providers will be left without a remedy under these circumstances is not necessarily correct. Here, the health care provider, as is typically true, obtained an assignment of the participant's rights under the plan before rendering the medical care. Respondent had the right, and exercised it in this case, to bring an action to enforce the

participant's rights under the plan. (Count III of respondent's complaint asserted a claim for benefits under the plan, and Count IV of respondent's complaint asserted a claim based upon the federal common law of equitable estoppel.) Thus, ERISA preemption would not leave the health care provider without a remedy, although it would limit the health care provider to the same remedies available to plan participants. Otherwise, the provider would be afforded greater remedies than could be exercised by the plan participant under the same circumstances.

A plan fiduciary's duty to provide information regarding the existence and extent of coverage under a benefit plan is a duty arising from its obligations as an ERISA entity. Therefore, any alleged breach of that duty should be determined by the uniform body of federal law under ERISA. State law which purports to regulate or to impose liability on the conduct of an ERISA entity arising out of the ERISA

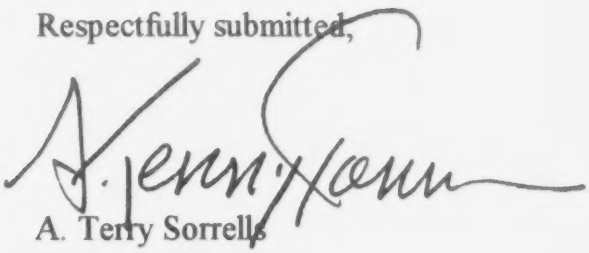
entity's fulfillment of its duties under ERISA should be preempted, without regard to the identity of the party plaintiff. Indeed, the plaintiff in Mackey, supra, was not "a party to the ERISA bargain" but was a collection agency. And, in Mackey, the Court held that plaintiff's cause of action based on a Georgia garnishment statute which singled out ERISA plans for different treatment was preempted. 486 U.S. at 830.

CONCLUSION

Petitioner respectfully urges this Court to grant a writ of certiorari to the United States Court of Appeals for the Eleventh Circuit so that this Court (1) can resolve the conflict between the Sixth Circuit and the Fifth, Ninth, Tenth, and Eleventh Circuit Courts of Appeal, and (2) can clarify the scope and extent of preemption and fill the interstices of the conclusory phrases used in Shaw, supra, between state laws which "relate to" a plan and are preempted and laws which

are "too tenuous, remote, or peripheral" to warrant preemption.

Respectfully submitted,



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APPENDIX A

LORDMANN ENTERPRISES, INC., Plaintiff-Appellant,

v.

EQUICOR, INC., Defendant-Appellee.

No. 93-9271.

United States Court of Appeals, Eleventh Circuit.

September 26, 1994.

Appeal from the United States District Court for the Northern District of Georgia.

Before COX, Circuit Judge, MORGAN, Senior Circuit Judge, and COLLIER*, District Judge.

COX, Circuit Judge:

Lordmann Enterprises, Inc. ("Lordmann"), a home health care provider, sued Equicor, Inc. ("Equicor"), an

*Honorable Lace Alexander Collier, U.S. District Court for the Northern District of Florida, sitting by designation.

insurer under an ERISA[1] plan, that Hi-Fi and Equicor could agree for Equicor to cover plan, to recover charges for nursing care provided to an Equicor insured. Lordmann asserted four different claims, and the district court granted Equicor summary judgment on all four. The significant issue raised on appeal is whether ERISA preempts Lordmann's Georgia law claim of negligent misrepresentation. We hold that it does not. On the other claims, we affirm the district court's grant of summary judgment in favor of Equicor.

I. Background

Paula Rebecca Mitchell ("Mitchell") and her daughter Victoria were provided coverage by a group insurance plan issued by First Equicor Life Insurance Company to Mitchell's employer, Hi-Fi Buys, Inc. ("Hi-Fi"). The defendant Equicor administered the plan. The plan provided coverage for thirty

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[1]Employee Retirement Income Security Act, 29 U.S.C. § 1001 et seq. (1988).

days of home nursing care per calendar year. It also provided that Hi-Fi and Equicor could agree for Equicor to cover rehabilitation services not otherwise covered under the plan if an insured became totally disabled because of "severe personal injury," a category that explicitly included neonatal high-risk infants. The First Equicor policy became effective June 1, 1990, and the Mitchells were covered by a policy issued to Hi-Fi by Blue Cross/Blue Shield until that date.

Victoria was born in February 1990 with severe birth defects that required her to spend her first five months in the hospital. After she went home, she needed twelve hours of nursing care a day. Mitchell hired a nurse employed by the plaintiff, Lordmann, to care for Victoria at home. Mitchell then assigned her rights under the insurance plan to Lordmann. The parties dispute the content of the communications that followed between Lordmann and Equicor. Lordmann contends that three weeks after it began

Victoria's care, Susan Marot, Lordmann's chief executive officer, telephoned Equicor to inquire into the extent of Mitchell's coverage under the plan. (R1-18-Ex. 1, Aff. of Susan C. Marot ¶ 9.) Marot spoke to Geri Castagno, an Equicor employee, who informed her that Hi-Fi's group insurance plan would pay 80% of the cost of home nursing. (Id.) A few days later, Castagno approved Lordmann's billing rate. (Id.)

Three months later, Marot again called Castagno to update Equicor on Victoria's condition. (Id. ¶ 10.) Castagno told Marot that she could not find where Hi-Fi's plan provided 80% coverage for Victoria's care, but Castagno informed Marot that Equicor's case management office had authority to alter the plan, and that Castagno would arrange for 100% coverage. (Id.) Lordmann continued to provide nursing care for Victoria. (Id. ¶ 8)

Six weeks later, Castagno called Marot and told her there was a problem with Victoria's coverage. (Id. ¶ 12.) Castagno did not elaborate, but when Marot asked if Lordmann should stop its care, Castagno again said that case management would alter the plan to cover the care. (Id.) Later the same day, Castagno called Marot again and informed her that Mitchell had not returned a case management form Castagno had sent. (Id.) Marot offered to have Mitchell return the form, but Castagno refused and instead told Marot that she was treating the case as if case management had never been involved. (Id.) When Marot asked if she should stop Victoria's care, Castagno again said no, assuring Marot that between Blue Cross/Blue Shield and Equicor, Lordmann's bill would be paid in full. (Id.) During this entire period Equicor monitored Lordmann's care for Victoria. (Id. ¶ 11.) Equicor never informed Lordmann that

the Hi-Fi plan covered only thirty days of home nursing care. (Id. ¶ 13.)

Equicor agrees that Marot spoke to Castagno, but Equicor contends that Castagno informed Marot that Equicor would pay for the services only according to the terms of Hi-Fi's group insurance plan. (R1-17-Ex. 15, Defendant's Response to Plaintiff's First Interrogatories, ¶ 8.)

Lordmann finished its care for Victoria a few weeks later, in early January, 1991, and sought payment from Equicor. In December, 1991, Equicor paid Lordmann $9,952, which was 80% of Lordmann's bill for thirty days of care in 1990 and four days of care (until it ceased) in 1991, less the amount owed by Blue Cross/Blue Shield for the same care. Lordmann also collected $3,425 from Blue Cross/Blue Shield, leaving a balance of $59,432.

Lordmann sued Equicor in state court in Georgia, asserting two claims. Count I is a state law claim based upon

alleged fraudulent misrepresentation. Count II is a state law claim based upon alleged negligent misrepresentations. Equicor removed to federal court, asserting federal question and diversity jurisdiction. After removal, Lordmann amended its complaint to add two federal claims, both asserted as Mitchell's assignee. Count III is an ERISA claim for benefits under the plan, and Count IV is an ERISA claim based upon the federal common law of equitable estoppel. Equicor moved for summary judgment on all four counts.

The district court granted Equicor's motion in full. It held that ERISA preempted the state law fraud and negligent misrepresentation claims. Lordmann Enterprises Inc. v. Equicor, Inc., No. 1:92-CV-2000-JOF, Order at 6 (N.D.Ga. October 2, 1993). The court granted summary judgment on the claim for benefits because it found no dispute over the terms of the plan. First, the plan unambiguously provided 80% coverage for thirty days of home nursing care, and

Equicor had already paid that amount. Id. at 8. Second, although the plan allowed Hi-Fi and Equicor to extend coverage for rehabilitation services to cover Victoria's care, Lordmann had presented no evidence of such an agreement. Id. at 10. Finally, the district court held that the plan provisions were unambiguous, and that under Eleventh Circuit precedent a claim based upon federal common law equitable estoppel is available only in cases involving the interpretation of ambiguous plan provisions. Id. at 11. This appeal follows.

II. Issues and Standard of Review

In this appeal, Lordmann challenges the district court's grant of summary judgment on all four counts. We review grants of summary judgment de novo. Reserve, Ltd v. Town of Longboat Key, 15 F.3d 1374, 1377 (11th Cir. 1994). Summary judgment is appropriate when there are no genuine issues of material fact and the movant is entitled to

judgment as a matter of law. Fed.R.Civ.P. 56(c). The court reviewing the motion must consider all evidence in the light most favorable to the nonmoving party. See United States v. Diebold, Inc., 369 U.S. 654, 655, 82 S. Ct. 993, 994, 8 L.Ed.2d. 176 (1962).

III. Discussion

A. State Law Claims

Lordmann contends on appeal that ERISA does not preempt Counts I and II, its state law claims of fraud and negligent misrepresentation. In response, Equicor argues that ERISA does preempt both claims, and in the alternative, that even if ERISA does not preempt them, summary judgment was appropriate because Lordmann had failed to show it could prevail under Georgia law. We agree with Equicor's state law argument that Lordmann has failed to show all the elements of the fraud claim, but we do not find state law to be dispositive on the negligent misrepresentation claim. Thus,

on that claim we must reach the preemption issue, and we hold that ERISA does not preempt a third-party health care provider's negligent misrepresentation claim against an ERISA plan administrator.

1. Fraud

Equicor contends that summary judgment is appropriate on the fraud claim, even if ERISA does not preempt it, because Lordmann has failed to present any evidence of scienter, a necessary element of fraud under Georgia law. See, Georgia-Pacific Corp. v. Lieberam, 959 F.2d 901, 907 (11th Cir. 1992) (listing elements of fraud under Georgia law). In response, Lordmann argues that under Georgia law scienter may be inferred from surrounding circumstances. McNeil v. Cowart, 186 Ga.App. 411, 367 S.E.2d 291, 293 (1988). However, scienter is not automatically inferable from the fact that the defendant made a misrepresentation. See Shaw v. Cook County Fed. Sav. &

Loan Ass'n, 139 Ga.App. 419, 228 S.E.2d 326, 328 (1976) (mere fact of savings & loan's misrepresentation to borrower that no liens existed on her house not sufficient to support fraud claim). As was the case in Shaw, Lordmann has pointed to no particular facts that could support an inference of scienter in this case. Even under Georgia's lenient standard of proof for scienter, Lordmann has failed to carry its burden on an essential element of its claim. Thus, the district court properly granted summary judgment on Count I. See Celotex Corp. v. Catrett, 477 U.S. 317, 321-23, 106 S. Ct. 2548, 2552, 91 L.Ed.2d 265 (1986).

2. Negligent Misrepresentation

Equicor argues that it is also entitled to summary judgment on the negligent misrepresentation claim because under Georgia law, statements as to the nature of insurance coverage are opinions of law and therefore not actionable for misrepresentation. See Marett Properties, Inc. v. Prudential

Ins. Co., 167 Ga.App. 631, 307 S.E.2d 69, 72 (1983); Parris & Son, Inc. v. Campbell, 128 Ga.App. 165, 196 S.E.2d 334, 337 (1973). However, as Lordmann points out, Georgia courts have expressly refrained from deciding whether this principle would deny recovery for misrepresentation when the plaintiff is neither the insured nor subrogated to the rights of the insured. Home Ins. Co. v. North River Ins. Co., 192 Ga.App. 551, 385 S.E.2d 736, 741 (1989). Because it is possible that Lordmann could prevail on its state law negligent misrepresentation claim, we must determine whether ERISA preempts such a claim.[2]

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[2]The district court did not address the state law claims because it found they were preempted by ERISA. See Lordmann Enterprises, Inc. v. Equicor, Inc., No. 1:92-CV-2000-JOF, Order at 4-6 (N.D. Ga. Oct. 2, 1993). Therefore, we express no opinion on the merits of the state law negligent misrepresentation claim and leave that issue for the district court to consider on remand. See Strength v. Hubert, 854 F.2d 421, 426 (11th Cir. 1988).

ERISA § 514(a) preempts all state laws insofar as they "relate to" any employee benefit plan covered by the Act. 29 U.S.C. § 1144(a) (1988). The parties do not challenge the district court's conclusion that the Hi-Fi group insurance plan is covered by ERISA. See 29 U.S.C. § 1002(1) (1988); Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982). Thus, the question is whether Lordmann's negligent misrepresentation claim "relates to" the group insurance plan. We conclude that it does not.

State law "relates to" an ERISA plan "if it has a connection with or reference to such a plan." Shaw v. Delta Air Lines. Inc., 463 U.S. 85, 96-97, 103 S. Ct. 2890, 2900, 77 L.Ed.2d 490 (1983). However, some state law may affect an ERISA plan in "too tenuous, remote, or peripheral a manner to warrant a finding that the law 'relates to' the plan." Id. at 100 n. 21, 103 S. Ct. at 2901 n. 21. Based on this Supreme Court interpretation of the statute, both the Fifth

and the Tenth Circuits have found that state law claims brought by health care providers against plan insurers too tenuously affect the ERISA plans to be preempted by the Act. Hospice of Metro Denver, Inc. v. Group Health Ins., 944 F.2d 752 (10th Cir. 1991); Memorial Hosp. Sys. v. Northbrook Life Ins. Co., 904 F.2d 236 (5th Cir. 1990). We agree.

The Memorial Hospital case presented facts very similar to Lordmann's. In that case, Gloria Echols, a covered dependent under a health insurance policy issued by Northbrook Life Insurance Company, sought care at Memorial Hospital. The hospital telephoned Northbrook Life to verify Echol's coverage, and a Northbrook Life employee confirmed that Echols was covered. The hospital then admitted Echols, who remained in the hospital for two months at a cost of more than $100,000. When the hospital submitted its bill, Northbrook Life informed the hospital of

Echol's ineligibility and denied the claim. Id. at 238. The hospital sued, alleging among other claims a violation of Texas Insurance Code article 21.21, which the court characterized as a Texas codification of negligent misrepresentation. Id. at 244.

The court concluded that ERISA did not preempt the statutory negligent misrepresentation claim for two primary reasons. First, preemption does not serve Congress's purpose for ERISA. Id. at 245. Congress enacted ERISA to protect the interests of employees and beneficiaries covered by benefit plans. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 113, 109 S. Ct. 948, 955, 103 L.Ed.2d 80 (1989). Preemption in a third-party health care provider case would defeat rather than promote this goal. The "commercial realities" of the health care industry require that health care providers be able to rely on the insurers' representations as to coverage. Memorial Hospital, 904 F.2d at 246. If ERISA

preempts their potential causes of action for misrepresentation, health care providers can no longer rely as freely and must either deny care or raise fees to protect themselves against the risk of noncoverage. In that event, the employees whom Congress sought to protect would find medical treatment more difficult to obtain. Id. Moreover, in this context disputes do not arise between the health care provider and the insurer under an ERISA plan, but "precisely because there is no ERISA plan coverage." Id.

Second, the Memorial Hospital court reasoned that health care providers were parties beyond ERISA's scope. See id. at 248-49. The Supreme Court has held that ERISA does not preempt "run-of-the-mill" claims by non-ERISA entities against ERISA plans. Mackey v. Lanier Collection Agency & Serv., Inc., 486 U.S. 825, 832-33, 108 S. Ct. 2182, 2186-87, 100 L.Ed.2d 836 (1988), and thus ERISA a fortiori does not preempt claims by health care providers

against a plan fiduciary. Memorial Hosp., 904 F.2d at 249. Moreover, a health care provider's claim against a provider of insurance under the plan affects the relationship between the principal ERISA entities at best only indirectly. Id. at 249. Finally, health care providers were not parties to the ERISA "bargain." Id. at 249. When employers and employees gave up state law causes of action because of ERISA, they received federal causes of action under ERISA in exchange. On the other hand, ERISA does not provide a cause of action for aggrieved health care providers that treat ERISA participants. Id.; see ERISA § 502(a), 29 U.S.C. § 1132(a) (1988 & Supp. IV 1992.)

Finding the Memorial Hospital court's reasoning persuasive, we hold that ERISA does not preempt a health care provider's negligent misrepresentation claim against an insurer under an ERISA plan. We thus reverse the district

court's grant of summary judgment on Count I and remand for further proceedings.

B. Derivative Claims

Lordmann argues that the district court erred in granting summary judgment on its claim as Mitchell's assignee under the Hi-Fi group insurance plan. The plan contains two provisions that Lordmann claims entitle it to payment. The first provides 80% coverage for the first thirty days of home nursing coverage in each calendar year. Lordmann does not dispute that Equicor has paid the amount due under that provision. However, Lordmann insists that it is also entitled to recover as Mitchell's assignee under a term covering rehabilitation services. The plan provides:

> This applies only to a person who: (a) is insured for Health Care Benefits; and (b) while so insured has

suffered a severe personal injury or sickness.[3] If he or she becomes totally disabled due to such injury or sickness, the Employer [Hi-Fi] and the Company [Equicor] may agree that:

1. The Company pay benefits for reasonable and customary charges for rehabilitation services and supplies furnished to such person; and

2. Such benefits will be paid to the extent that they are in excess of the total benefits payable for such charges under all other parts of the plan . . . . The amount of such benefits will be determined by the Company.

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[3]The plan gives an exclusive list of "severe personal injur[ies] or sickness[es]." "Neonatal high risk infants" appears on the list. (R1-17-Ex.3, Plan Booklet at 16.)

(R1-17-Ex.3, Plan Booklet at 16.) The provision unambiguously requires that Equicor and Hi-Fi agree for the additional benefits to become available. Lordmann argues that Castagno's representations to Marot were sufficient to put in issue the existence of an agreement. We disagree. The provision requires that both Hi-Fi and Equicor agree, and Lordmann has not presented evidence to suggest that Hi-Fi assented to Equicor's coverage of Victoria's care.[4] The district court was therefore correct in granting summary judgment for Equicor on Count III.

C. Equitable Estoppel

ERISA forbids oral modification of plan terms. Nachwalter v. Christie, 805 F.2d 956, 959 (11th Cir. 1986). However, this court has recognized a cause of action for

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[4]We note that the benefit booklet does not define "rehabilitation services," but Equicor has not argued that home nursing care for a newborn is not a "rehabilitation service."

equitable estoppel when a plan administrator makes a representation that interprets, rather than modifies, an ambiguous term of the plan. Alday v. Container Corp., 906 F.2d 660, 666 (11th Cir. 1990), cert. denied, 498 U.S. 1026, 111 S. Ct. 675, 112 L.Ed.2d 668 (1991); Kane v. Aetna Life Ins., 893 F.2d 1283, 1285 (11th Cir.), cert. denied, 498 U.S. 890, 111 S. Ct. 232, 112 L.Ed.2d 192 (1990). Lordmann argues that Castagno's representations were interpretations of the rehabilitative services provision, and that therefore Equicor should be estopped from asserting an alternate interpretation. We disagree.

In Kane, the provision that formed the basis of the administrator's representation was ambiguous.[5] Id. at 1286.

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[5]In Kane, two terms were at issue. One provided that "[f]ull time employees . . . and their eligible dependents will be covered under he plan . . . on the first day of the months in which the employee will complete a Term of Employment of six (6) months. No benefits are covered for charges incurred during a continuous

(continued...)

The provision Lordmann relies upon to contend that Castagno was interpreting the plan, rather than modifying it, is unambiguous. The rehabilitation services provision clearly requires that Hi-Fi and Equicor agree to extend coverage to long-term rehabilitation services. Lordmann has offered no evidence of any agreement between Hi-Fi and Equicor. Without an agreement under this provision, we must view any

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[5](...continued)
hospital confinement which commenced prior to the effective date of coverage . . . ." Kane, 893 F.2d at 1285-86. Another provided that adopted children became eligible dependents upon the commencement of formal adoption proceedings. Id. at 1284 n. 1. The plaintiff, an employee covered by the plan, had adopted a hospitalized newborn after the insurance plan administrator had assured her that the child's medical care would be covered. After the child was released from the hospital, however, the insurer denied the claim, contending that the child was already hospitalized on the effective date of coverage (the date of adoption). The Kane court found that the provision defining the effective date of coverage could be read two ways, yielding two possible outcomes: an adoptee's coverage could become effective when the employee had worked six months, or an adoptee's coverage could not take effect until the parents instituted formal adoption proceedings. Id. at 1286.

statement made by Equicor concerning the provision as a modification of the plan rather than an interpretation of the extent of an agreement between Hi-Fi and Equicor. Thus, Kane does not apply, and this case falls under Nachwalter's rule against oral modifications of ERISA plans. Summary judgment was appropriate on Count IV.

IV. Conclusion

For the foregoing reasons, we AFFIRM the district court's grant of summary judgment as to Counts I, III, and IV. However, we REVERSE summary judgment as to Count II, the negligent misrepresentation claim, and REMAND for further proceedings.

AFFIRMED in part; REVERSED and REMANDED in part.

APPENDIX B

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF GEORGIA
ATLANTA DIVISION

Lordmann Enterprises, Inc.,	)	
	)	
Plaintiff,	)	
	)	CIVIL ACTION NO.
v.	)	
	)	1:92-CV-2000-JOF
Equicor, Inc.,	)	
	)	
Defendant.	)	

ORDER

This matter is before the court on Defendant's motion for summary judgment and Plaintiff's motion for leave to file a reply brief in support of its response to Defendant's motion for summary judgment. Because the court finds Defendant's reply brief attached to its motion for leave to file that brief helpful in resolving Defendant's motion for summary

judgment, Plaintiff's motion for leave to file a reply brief [22-1] is GRANTED.

I. BACKGROUND

Paula Mitchell and her daughter, Victoria, were insured by a group insurance plan issued by First Equicor Life Insurance Company ("First Equicor") to Mitchell's employer, Hi-Fi Buys, Inc. ("Hi-Fi Buys"). Claims were administered by Defendant Equicor, Inc. ("Equicor"). There is no dispute that both Paula and Victoria Mitchell were eligible for benefits under the First Equicor policy.

When Victoria was born on February 18, 1990, she was placed in the neonatal intensive care unit of Grady Hospital, and later moved to the intermediate nursery, where she remained until she went home on July 30, 1990. Victoria suffered from numerous physical problems, which required nursing care twelve hours daily after her discharge. Plaintiff Lordmann Enterprises ("Lordmann") is a provider of home

nursing care services, and Mitchell hired a Lordmann nurse who had cared for Victoria in the hospital to continue with the home health care. Lordmann now is the assignee of Ms. Mitchell's employee benefits under the Hi-Fi Buys Plan.

In late July, the Chief Executive Officer of Lordmann, Susan Marot, contacted Hi-Fi Buys to discuss Mitchell's insurance coverage, and was referred to Equicor's Medical Case Management. Marot spoke with Geri Castagno of Medical Case Management. According to Marot, Castagno informed her that the insurance policy under which Mitchell was covered would provide eighty percent coverage for the nursing care proposed. Marot further states that she spoke with Castagno on October 31, 1990, and was told that Castagno had authority to alter the benefits paid and that she would arrange to have 100% of the charges for nursing care paid. On December 11, 1990, Marot states that Castagno called her and told her that there was a question about

coverage, but that Medical Case Management had authority to alter the plan, and Plaintiff's services rendered would be covered at a 100% rate. Later that day, Castagno called again and again raised some question as to coverage, but stated that Lordmann would need to bill Blue Cross/Blue Shield first and that Equicor would pay the balance, so that Lordmann would be paid 100% for its services rendered. Marot asked during both calls whether she should discontinue the nursing services, and she was told that there was no need to do so. Plaintiff alleges that Medical Case Management monitored the services rendered continuously from July 30, 1990, through January 4, 1991, and that no mention was made during that time of any limitation on coverage for the nursing services.

Equicor alleges that Marot did speak with Castagno, but that Castagno stated only that the nursing services "would be covered under group policy number 72610, or not

covered, subject to the terms and conditions of the contract of insurance."

In December of 1991, Equicor paid Lordmann $9,952.40 and denied the $59,432.40 remaining balance, stating that nursing charges were allowed under the insurance policy for only thirty days. Because Equicor had paid for three days of nursing care earlier in the year, Equicor paid for twenty-seven days of nursing care provided by Lordmann. Equicor further deducted the amount of payments made by Blue Cross/Blue Shield to Lordmann pursuant to a non-duplication provision of the insurance policy.

Plaintiff filed suit seeking damages for Defendant's alleged fraud and negligent misrepresentation (counts I and II) and was granted leave to amend the complaint to add two additional counts seeking payment of the plan benefits based on the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, et seq. (count III), and on

ERISA and the federal common law of equitable estoppel (count IV).

Defendant has moved for summary judgment, asserting that counts I and II state no cause of action under Georgia law or, alternatively, that such claims are preempted by ERISA, and that Defendant is entitled to judgment as a matter of law on counts III and IV.

II. DISCUSSION

A. Fraud/Negligent Misrepresentation

Lordmann alleges that Equicor fraudulently or negligently misrepresented to Lordmann that it would be fully paid for all nursing services rendered to Victoria Mitchell, that Lordmann justifiably relied on Equicor's misrepresentation, and that Lordmann was injured as a result of its reliance. Equicor has asserted that Lordmann's allegations do not state a cause of action under Georgia law,

or, alternatively, that Lordmann's state law claims are preempted by ERISA.

The insurance plan provided to Mitchell by Hi-Fi Buys is undisputedly an employee welfare benefit plan subject to ERISA regulation. See 29 U.S.C. § 1002(l) and (3); Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44 (1987); O'Reilly v. Ceuleers, 912 F.2d 1383, 1387 (11th Cir. 1990); Donovan v. Dillingham, 688 F.2d 1367, 1371 (11th Cir. 1982). Section 1144(a) preempts "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA, with certain exceptions, not here relevant, outlined in § 1144(b)(2)(A) and (b)(4).

Consequently, the court must determine whether Lordmann's state law claims of fraudulent or negligent misrepresentation "relate to" the employee benefit plan so as to be preempted by ERISA. "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a

connection with or reference to such a plan." Shaw v. Delta Air Lines Inc., 463 U.S. 85, 96-97 (1983). "[A] state law may 'relate to' a benefit plan, and thereby be preempted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990); Shaw, 463 U.S. at 98. A broad interpretation of "relates to" has been accorded by courts, in order to implement the Congressional intent of protecting employees with a uniform federal law governing their benefit programs. Id. Thus, common law tort and contract actions asserting improper processing of a claim for benefits under an ERISA-governed plan have been held to be preempted. Dedeaux, 481 U.S. 41. Some "run-of-the-mill" state actions may, however, survive. Mackey v. Lanier Collection Agency, 486 U.S. 825 (1988). Here, while Lordmann's common law claims of fraudulent or negligent misrepresentation do not directly implicate the employee benefit plan, they do have a

clear "connection with or reference to such a plan" in this instance. Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 739 (1985). Lordmann, while alternatively claiming to be an assignee of a plan beneficiary, is endeavoring to do that which a beneficiary cannot do under state law, and that is to recover based on alleged oral representation about the coverage of the plan. Assignments of plan benefits to health service providers is not uncommon, and it is not uncommon for those providers to act for the beneficiary on coverage issues. To allow those providers under these circumstances to move against the plan under state law would frustrate a major objective of the preemption doctrine and of ERISA. Consequently, Lordmann's state law claims are preempted by 29 U.S.C. § 1144(a), and this court lacks jurisdiction to adjudicate those claims. Hermann Hospital v. MEBA Medical & Benefit Plan, 959 F.2d 569 (5th Cir. 1992).

B. Count III

Count III of Plaintiff's amended complaint claims that as Mitchell's assignee[1], Lordmann is entitled to payment for all services rendered pursuant to the insurance policy. Lordmann alleges that as the plan's claims administrator, Equicor is a fiduciary within the definition of 29 U.S.C. § 1002(21)(A),[2] responsible for carrying out the duties set forth in 29 U.S.C. § 1104. See Massachusetts Mutual Life

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1It appears that although assignees are not specifically enumerated as having standing to sue under ERISA, such standing generally will be accorded. See, e.g., Kennedy v. Connecticut General Life Ins. Co., 924 F.2d 698 (7th Cir. 1991); Hermann Hospital v. MEBA Medical and Benefits Plan, 845 F.2d 1286, 1287 (5th Cir. 1988); Misic v. Building Service Employee's Health, 789 F.2d 1374, 1377 (9th Cir. 1986); Miami Children's Hospital, Inc. v. Malakoff, 765 F. Supp. 718, 720 (S.D. Fla. 1991).

2Although no evidence has been submitted to prove that Defendant is in fact a fiduciary, Defendant has not challenged that categorization. Therefore, Defendant's status as a fiduciary is assumed for the sake of argument. See Baker v. Big Star Division of Grand Union Co., 893 F.2d 288 (11th Cir. 1989).

Ins. Co. v. Russell, 473 U.S. 134, 142 (1985) (the fiduciary's obligation is to serve the interests of the plan's participants and beneficiaries and "specifically, to provide them with the benefits authorized by the plan.").

Equicor argues that all benefits due under the policy have been paid. According to Defendant, the benefits for at-home nursing care were expressly limited to thirty days per year, the policy provided for eighty percent coverage of the charges, and a "co-insurance" provision would reduce the benefits paid by Defendant in the amount of benefits paid by other insurance companies so that the insured would recover in total no more than the plan's total benefits. After these deductions had taken place, the $9,952.40 paid on December 23, 1991, is the total amount due, according to Equicor. The relevant language of the first EQUICOR-Hi-Fi Buys "Your Group Benefits Plan" booklet-certificate

("booklet") outlining limitations pointed out by Equicor reads:

> WHAT ARE COVERED CHARGES .
> 6. Charges for private nursing made by
> (a) a registered nurse (R.N.).
> (b) a licensed practical nurse (L.P.N.).
> (c) a licensed vocational nurse (L.V.N.).
> Charges for such services done while the person is not confined to a hospital will be covered for up to thirty days in a calendar year.

Booklet, p. 7.

> HOW MUCH
>
> . . . You will be paid at the co-insurance rate shown in the schedule of benefits.

Booklet, p. 9.

> CO-INSURANCE RATE . . . 80%, after satisfying the deductible.

Booklet, p. ii.

> NON-DUPLICATION OF BENEFITS
> If an insured person is entitled to benefits for medical or dental care under this plan and at least one other plan, the amount of benefits provided by this plan for that care

> may be reduced to the extent that the total payment provided for a calendar year by all plans by which the person is covered will not be more than the total of the allowable expenses that the person incurs in the same year.

Booklet, p. 32.

Insurance is a matter of contract, and the rules regarding contract interpretation apply when construing an insurance policy. Richards v. Hanover Ins. Co., 250 Ga. 613, 614, 299 S.E.2d 561 (1983); Barker v. Coastal States Life Ins. Co., 138 Ga. App. 164, 166, 225 S.E.2d 924 (1976); North British and Mercantile Ins. Co. v. Tye, 1 Ga. App. 380, 389, 58 S.E. 110 (1907). "There is no greater sanctity and no more mystery about a contract of insurance than any other. The same rules of construction apply to it as to other contracts . . . ." Clay v. Phoenix Ins. Co., 97 Ga. 44, 53, 25 S.E. 417 (1895). Therefore, an unambiguous insurance

contract as any other contract must be construed to mean what it says. Fox v. Southern Glassine Co., 130 Ga. App. 124, 202 S.E.2d 563 (1973); Cherokee Credit Life Ins. Co. v. Baker, 119 Ga. App. 579, 582, 168 S.E.2d 171 (1969). The rule applies equally to language which limits insurance coverage. Baker at 582; State Farm Mutual Auto Ins. Co. v. Sewell, 223 Ga. 31, 32, 153 S.E.2d 432 (1967).

In this instance, the language is clear and free from ambiguity, and according to the terms of the contract, by paying Lordmann for twenty-seven days of nursing care (three days having been paid earlier to another provider) at eighty percent coverage, less the amount paid to Lordmann by Blue Cross/Blue Shield, Equicor has met its obligations under the terms of the policy.

However, Plaintiff points to a provision for benefits payable for rehabilitation services, the relevant portion of which states:

This applies only to a person who: (a) is insured for health care benefits; and (b) while so insured has suffered a severe personal injury or sickness. If he or she becomes totally disabled due to such injury or sickness, the employer and the company may agree that:

1. The company pay benefits for reasonable and customary charges for rehabilitation services and supplies furnished to such person; and

2. Such benefits will be paid to the extent that they are in excess of the total benefits payable for such charges under all other parts of the plan . . . .

As used above "a severe personal injury or sickness" means any of the following . . . neonatal high risk infants . . . . Any agreement to pay benefits in accord with

1. and 2. above will be based on an objective review of:

(a) the medical status;

(b) the current treatment plan;

(c) the projected treatment plan;

(d) the long term cost implication; and

(e) the effectiveness of care.

Booklet, p. 16.

Plaintiff asserts that because Victoria was a neonatal high risk infant who was totally disabled as a result of her physical condition, rehabilitative services[3] rendered by Lordmann are therefore covered, entitling Plaintiff to reimbursement for the remaining balance. Equicor has objected that in so claiming Lordmann ignores the language

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[3]The term "rehabilitation services" is not defined in the booklet-certificate, but Equicor has not objected to Lordmann's implicit assertion that the nursing services were rehabilitative in nature.

requiring an agreement between the employer and Equicor before rehabilitation services are covered, and that, because no evidence of such agreement has been offered, Lordmann has failed to present evidence on an element essential to its case, requiring entry of summary judgment in Equicor's favor. Plaintiff makes three responses: First, that the promise to pay rehabilitation benefits pursuant to an agreement entered between the employer and Equicor is illusory; second, that Equicor is equitably estopped from denying that such an agreement existed because of the representations made to Lordmann by Equicor's agent; and third, that Lordmann has in fact offered sufficient proof of an agreement between Equicor and Hi-Fi Buys.

However, all of these arguments fail for the same reason: There is no evidence anywhere in the record that Castagno made any representation about the availability of rehabilitation benefits, or even any reference to that provision

of the insurance contract. Without at least some reference by Equicor to that provision, Lordmann can show no genuine issue of material fact which would prevent entry of summary judgment.

C. Count IV

Count IV of Lordmann's amended complaint claims that Equicor fraudulently or negligently represented to Lordmann that all services rendered would be covered by the insurance plan, that Lordmann relied on that representation, and that under ERISA and the federal common law of equitable estoppel, Equicor should be estopped from denying coverage.

In Kane v. Aetna Life Ins., 893 F.2d 1283 (11th Cir. 1990), the court recognized that the federal common law of equitable estoppel may be applied to an ERISA-governed insurance plan when an oral interpretation of an ambiguous provision of the contract is made to an employee and the

employee relies on that interpretation. Several cases following Kane have either applied equitable estoppel or expressly left open the possibility that equitable estoppel could be applied in an instance when there is no ambiguity, but when the insurer makes a fraudulent representation. See, e.g., Alday v. Container Corp. of America, 906 F.2d 660 666 n.15 (11th Cir. 1990) ("We note that our holding does not insulate from liability a fiduciary who makes fraudulent promises in informal communications that deceive employees and contradict the terms of the SPD [summary plan description]. In such a case, there may be valid reasons for a court to look beyond the unambiguous language of the SPD in interpreting the plan.").

However, the federal common law of equitable estoppel cannot assist Plaintiff. There is no ambiguity in the terms of the plan that would allow an application of equitable

estoppel. Even assuming that a fraudulent misrepresentation about insurance coverage could serve as the basis for an application of equitable estoppel as suggested by the Alday dicta, Lordmann has failed to adduce any evidence of Equicor's intent to deceive, and consequently, there is no evidence of fraud. Without an interpretation of an ambiguity or a fraudulent misrepresentation, Lordmann is left with only an oral modification of an ERISA-governed insurance plan, which cannot be enforced. See Nachwalter v. Christie, 805 F.2d 956, 960 (11th Cir. 1986).

III. SUMMARY

Plaintiff's motion for leave to file a reply brief [22-1] is GRANTED, and for the foregoing reasons, Defendant's motion for summary judgment [17-1] is GRANTED.

SO ORDERED, this 30th day of September, 1993.

/s/
J. OWEN FORRESTER
UNITED STATES DISTRICT JUDGE

APPENDIX C
IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 93-9271

LORDMANN ENTERPRISES, INC.,

Plaintiff-Appellant,

versus

EQUICOR, INC.,

Defendant-Appellee.

On Appeal from the United States District Court for the
Northern District of Georgia

ON PETITION(S) FOR REHEARING AND

SUGGESTION(S) OF REHEARING EN BANC

Before: COX, Circuit Judge, MORGAN, Senior Circuit Judge, and COLLIER*, District Judge.

PER CURIAM:

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*Honorable Lacey Alexander Collier, U.S. District Judge for the Northern District of Florida, sitting by designation.

(x) The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT

/S/ Emmett R. Cox
UNITED STATES CIRCUIT JUDGE

FILED
U.S. COURT OF APPEALS
ELEVENTH CIRCUIT
FEB 1, 1995
MIGUEL J. CORTEZ
CLERK

APPENDIX D

SECTION 514(a) OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974, 29 U.S.C. § 1144(a)

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.